



Learning point

The use of interpreters in medical settings and forensic medical examinations in Australia: The relationship between medicine and linguistics



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ABSTRACT

Medical examinations are dependent on combining communication with professional competence. In the development of a global multicultural community with the use of multiple languages, doctors have become increasingly dependent on language facilitation such as interpreting and translation. Despite professional studies, the use of language facilitation with its associated problems has not been fully explored in graduate and post-graduate medical and forensic medical training. There may still be some lack of reciprocal understanding between the medical and linguistic fields, their ethics, obligations and limits although both fields and their ethical frameworks are closer related than might be expected. This article is a discussion that aims at providing a basic understanding of guidelines as to the origin and appropriate use of language interpretation in medical and forensic medical examinations.

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1. Introduction

“Communication is the exchange of messages and thoughts by speech, signals or writing. Communication skills are used to ensure that exchanges are readily and clearly understood. Exchanges involve the sharing of information, ideas, emotions and empathy. Communication constitutes the foundation on which medical consultation develops in addition to the doctor’s skill in physical examination and diagnostic reasoning. Failure of communication is an important contributor to clinical situations of misadventure or malpractice and is an important factor in many medico-legal actions. Most medical consultations and activities require the doctor and patient to communicate rationally and effectively with each other”.¹

Communication is an essential aspect of medical assessments. The exchange of information between the doctor and patient is

necessary for providing the patient with sufficient information, assessing his or her capacity, obtaining legally valid consent, understanding the patient’s problems and appropriately responding to them. Virtually the entire discharge of relevant obligations the doctor has towards the patient is dependent on the articulation and reception of language enabling mutual understanding. Early in their clinical education, doctors are taught, “a careful history will lead to the diagnosis 80% of the time”.² This aphorism or statements such as, “the diagnosis is in the referral letter” together with reminding doctors that carefully and attentively listening to their patients is prudent and fruitful³ imply that language should be conveyed as unambiguously as possible. The Australian Medical Council (AMC) dedicates a whole chapter with Multidisciplinary Clinical Assessment Task (MCAT) scenarios to “Clinical Communication” in their “Handbook of Clinical Assessment”: effective communication, counselling and patient education as well as case presentations and summaries from overseas qualified medical practitioners mainly from non-English speaking countries seeking registration to practise medicine in Australia are assessed according to a set verbal and nonverbal communication and “bedside manner” standard.¹

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Relevant in particular for the Forensic Physician but also for the entire spectrum of Health Professionals is the recognition made by Alan T. Rose in the AMC Handbook of Clinical Assessment: “Similarly, the cultural characteristics of the patient (and of the doctor) can profoundly affect the quality of doctor–patient communication. Doctors practising in Australia require multicultural competence across all fields of medicine. Special care is required in the case of Aboriginal and Torres Strait Islanders, and for culturally and linguistically diverse groups. Communication skills, although important, are not sufficient. Good communication skills must be accompanied by sound clinical skills, attitudes and professional behaviour. The (fortunately) rare physician serial criminal murderers have usually been superb communicators. Other personal factors can interfere with the doctor’s use of communication skills. Many clinical realities are unpleasant to both patient and doctor. If the doctor retreats behind a professional façade of a stilted and portentous style of speech, or adopts a pompous or pretentious attitude, or one interpreted as such, the patient can be daunted from further enquiry. Rejection by the doctor of a patient’s attitude or behaviour engenders lack of understanding and trust. Value judgements of the doctor are best avoided or concealed. Care and compassion should be evident but not forced or obtrusive. This is especially important when treating users of illicit drugs or dependent alcoholics. Mention should also be made of the so-called ‘difficult patient’ whose underlying but sometimes unrecognised personality disorder reduces or eliminates the effectiveness of the communication skills described below”.¹

Much effort is made in the application of proper communication in the nationally and culturally dominant language by teaching and educational institutes and authorities. Articulation in the specialised language of medical practice is naturally developed, exercised, drilled and scrutinised by the practitioner over a considerable time. A sophisticated professional eloquence may be the result with the doctor being able to express himself both in the professional jargon and common terms of his profession and the community. In his communication with others in the same language, the doctor is dependent on his trained style, speech, voice, expression, gesture and mimicry. He appears to be in control over his means of communication.

2. The patient who only speaks a foreign language

The scenario is different when the patient does not converse in the doctor’s language and vice versa. Suddenly, the doctor’s empathy, understanding and advice cannot be expressed using the native means of communication. The well-trained speech, questions and explanations are not intelligible to the patient. The doctor, normally able to guide and advise a person in need, suddenly finds himself or herself helpless and frustratingly ineffective. This may pose a challenge to the doctor’s character, attitude and experience. On the other hand, the patient cannot convey the problem to the doctor and due to lack of understanding, the capacity to communicate and competently make decisions is significantly reduced during the doctor–patient interaction. An aid, in the person of a language-interpreter, is required. This aid is a human being lending his or her hearing, mind and speech to both the doctor and patient, transmitting and conveying the information to the other party consecutively or simultaneously. The presence of this third person may change the dynamics of the interaction and poses new challenges with a range of ethical implications. Effective use of an interpreter requires an understanding of how to use this facilitator of communication properly. Also the interpreter is subject to a framework of ethical principles such as confidentiality and other duties and limitations. Thus, these ethical guidelines become relevant.

It is important to understand the difference between an interpreter and translator. An interpreter is defined as someone who conveys an oral message or statement from one language to another, whereas a translator is someone who conveys written messages or statements from one language to another.

3. Relation between medicine and interpreting in the scientific paradigm

Although interpersonal and communication skills based on the appropriate use of language and an acceptable psychological approach of the doctor may fall under the academic area of the humanities, medicine traditionally regards itself as a biological science, belonging more to the family of natural sciences^{4,5} than to humanities. However, there is also a recognition that medicine is part of both natural science and the humanities.⁶ The discussion whether medicine is science, art or both is an eternal one.⁷ Interpreting and translating, in contrast, are part of applied linguistics, an interdisciplinary field related to education, psychology, communication research, anthropology and sociology, belonging to the human sciences.⁶

4. Intercultural problems

In a forensic medical fitness-for-interview assessment, as well as in any other medical assessment, doctors of different cultural and language backgrounds may have different ways of articulation and expressing themselves. What seems to be self-evident for an English-speaking medical practitioner may be a major problem for overseas trained doctors in Australia. In different cultures there may be different meanings given to the empathic way of asking a question, comforting the patient by a balanced way of coming from open questions to leading closed questions, appropriately encouraging the patient to continue with describing the problem, showing concern, re-assuring the patient by nodding or shaking the head, leaning forward, expressing concern, repeating key phrases and showing understanding. In their testing procedures, the Australian Medical Council seems to have recognised this problem in that medically and scientifically highly trained foreign practitioners even with sufficient knowledge of English are sometimes seen to display awkward and inappropriate interpersonal contact with the patient. This can have the result that the patient would not feel comfortable enough to interact with the doctor’s questions, conclusions and advice.⁸

5. Whom does it concern?

Despite the fact that the main language spoken in Australia is English, there are many who don’t speak it. They may be descendants of indigenous inhabitants, descendants of immigrants or may be recent immigrants from non-English speaking countries. These people may need medical attention including forensic medical services. Other non-English speaking people may be in the country as temporary visitors or tourists. General globalisation results in the existence with a broad spectrum of languages within any geographic area. These changes have driven government authorities to take measures in order to cope with increasing demands on language. Whereas in England the public translation and interpretation service was recently handed to a single company,⁹ the service in Australia follows accreditation by the National Accreditation Authority for Translators and Interpreters (NAATI)¹⁰ involving governmental¹¹ or agency services.

6. Ethical problems as to medicine and foreign language

Both the medical and the interpreting fields are framed in a tight modern ethical code. However, each seems to lack awareness of the

obligations and duties binding the other.¹² The need of an interpreter is also considered somewhat marginal by some medical professionals or health institutions¹³ and their use does not seem to be fully understood. The problem may be associated with the fact that second-language acquisition is an academic discipline by itself, a sub-discipline of applied linguistics with the intellectual and also emotional process of learning a second language being divided into five stages: preproduction, early production, speech emergence, intermediate fluency and advanced fluency.¹⁴ As with any skill, the efforts of engaging into this interdisciplinary field may be quite time consuming. Further, there are over 7105 living languages throughout the world according to *Ethnologue*¹⁵ published by the Summer Institute of Linguistics.¹⁶ Thus, even a multilingual doctor will at some stage face a patient whose language he or she does not understand and for whom an interpreter is required in order to communicate.¹⁷

Another ethical question arises that concerns Australia in particular. Due to the multiplicity of indigenous dialects in Australia, many cases involving Aboriginal victims of alleged physical or sexual assault have had to be dropped because no interpreter could be found.^{18–20} More research is needed regarding this frequently alleged problem. It also concerns fitness-for-interview assessments.^{21,22} Possible lack of interpreters or translators raises the question whether a member of an isolated aboriginal community, who has to undertake the enormous intellectual effort to study a second language to be heard, can find justice and be able to engage with services.

Learning a second language is an extra-ordinary task possibly involving financial strain and several years of studying, training and engagement. Should such efforts be expected by either the indigenous patient or the doctor? Or, is the answer to this problem found in an established and well-organised service of appropriately trained and accredited interpreters and translators. Then due respect to this interdisciplinary academic field as well as appropriate training and understanding how to use this service is required.

It has now been more than 200 years since the first British colonisation of Australia and most indigenous communities will have been integrated, brought up in an English speaking environment or at least exposed to it on a daily basis. This is certainly the case in urban environments. However, there are a few indigenous communities where a form of English is not spoken and they tend to be small and isolated. Walsh distinguishes between 350 and 750 Aboriginal languages and dialects.²³ According to Dalby 150 of them have remained in daily use in the 21st century.²⁴ For many of them, NAATI does not have accredited or recognised interpreters on their registration list. Many indigenous languages are not even known now. There are also dialects or idiomatic forms of English and pidgin English that may have to be contended with. However, this is also a problem for non-indigenous communities such as for example some Asian communities. The existence of such communities may render finding a competent interpreter very difficult. Sometimes the language is so rare that only a family member may be found who could act as an interpreter. Questions as to motivation, interest and ethical standards such as confidentiality and accuracy arise.

7. The Nuremberg Trials and the ethical codes

Although both modern medical ethics and the profession of simultaneous interpreting have their origins in the outcome of one of the most devastating world events in history, that is World War II, both disciplines seemed to have drifted apart during the following decades and found themselves in a position of taking the other's field somewhat for granted. The Nuremberg Trials took

place between November 1945 and October 1946, and established the Nuremberg Code,²⁵ a set of medical and research ethics including essential medical principles such as informed consent and absence of constraint or coercion on which modern medical ethics are built. The Nuremberg Trials posed a unique challenge in that forensic investigations in a vast scope were undertaken beyond the borders of a single language. Gravity, length and intensity of these trials of several medical doctors who became examples of extraordinary breach of human rights, crimes, professional misconduct and misbehaviour gave birth to the professional field of simultaneous interpreting.²⁶ In her book "The Origins of Simultaneous Interpretation: The Nuremberg Trial", Francesca Gaiba describes this extraordinary task by the Allied judiciary of conveying what was said concerning crimes, forensics, medicine, experiments and ethics through interpreters on an international platform. The intense process of listening and verbal expression far beyond dictation speed,²⁷ with low tolerance for mistakes or human errors,²⁸ over periods of hours,^{29,30} days, weeks and months, and the emotional strain due to the contents of horrific³¹ and degrading nature such as torture disguised in mind- and thought-provoking euphemisms, resulted in shock, distress, breaking down and crying by interpreters, a condition we describe as vicarious trauma, related to the spectrum of post-traumatic stress disorder.³² The Nuremberg Trials influenced the ethical codes throughout the world.

In Australia, the ethical code for translators and interpreters is set out by the Australian Institute of Interpreters and Translators (AUSIT). This organisation regulates professional conduct, confidentiality, competence, impartiality, accuracy, clarity of role boundaries, maintenance of professional relationships, professional development and professional solidarity of the profession. As with medicine and in particular forensic medicine, translators and interpreters may find themselves in a position of dual obligation or a situation in which clients or third parties assume dual obligation of them. In this case, the ethical code states, "Interpreters and translators do not, in the course of their interpreting or translation duties, assume other roles such as offering advocacy, guidance or advice. Even where such other tasks are mandated (e.g. by specific institutional requirements for employees), practitioners insist that a clear demarcation is agreed on by all parties between interpreting and translating and other tasks".³³ Thus, interpreters are not doctors, psychologists, advocates, second assessors of capacity or guarantors of understanding. They cannot give medical advice but merely transfer the medical advice by the doctor into the patient's language. They cannot advise the doctor that the patient is of sound understanding or has capacity to make a decision, but can only convey the answers they receive from the patient. They should not be obliged to judge if the patient's answer is logical or relevant. The doctor should conclude this by himself through appropriate formulation of the questions. AUSIT states in specific Conduct Issues, "Interpreters testify to their qualifications and the accuracy of their interpreting and, when requested, explain their linguistic choices, but do not testify to participants' understanding of messages; this remains an issue for participants."

8. Fitness for interview assessment

In a fitness for interview assessment, the forensic physician's primary concern among others is to recognize any characteristics that might render the individual vulnerable to providing a false confession so that adequate safeguards can be put in place.³⁴ It is self-evident that lack of understanding the language and misunderstandings related to the interpreting process may impair reliability and could contribute to falsely incriminating the interviewee. Besides reliability of the interview, assessing fitness for

interview serves also to prevent significant physical or mental harm in the interviewee or detainee.³⁵ The doctor may identify the need for an interpreter by asking his patient an open question which cannot be simply answered by “yes” or “no”. An example can be, “Where do you live?” Otherwise, the doctor may ask the patient to repeat a statement he has just spoken in the patient’s own words. A simple capacity assessment to gain consent will help identify a language barrier. Apart from not being conversant in the doctor’s language, there may other conditions that could impair the patient’s understanding such as being hard of hearing or mental impairment. In the end the Forensic Physician should be confident to advise and guide the police whether the subject is fit to undergo questioning with the intentions of finding out whether the subject engaged or participated in criminal behaviour. The conclusion is mainly if not entirely drawn from what is said. Thus, communication is the key factor that decides on whether a person will be at freedom, imprisoned, financially compromised or vilified. Georgina Heydon, Forensic Linguist, outlined this problem in her book, “The Language of Police Interviewing”. She found in her examination of the relationship between language and the law a discrepancy between the specific implications for the discursive construction of the interview imposed on the police officer by legislative requirements and the individualistic way of expression in the subject.³⁶ This appeared to cause miscommunication within the area of the English language alone. Much more care is required to convey information accurately in a setting where the interviewer and interviewee speak different languages. Miscommunication and misunderstandings can have horrendous consequences regarding the future of a subject, be it suspect or victim. All efforts are to be made to provide the clearest and least ambiguous language transmission possible.

9. Guidelines

Therefore, guidelines regarding how to use an interpreter should be established, respected and adhered to. In order effectively to use an interpreter, the doctor should be aware of the following³⁷:

- a) The doctor should inform the interpreter of the purpose of the medical assessment. This can be done in the notes section of a booking form or at a meeting prior to the appointment. This will help the interpreter prepare for the appointment so that all parties will be better understood.
- b) The doctor should position the interpreter appropriately in clear earshot. If the setting is very graphic such as a patient or detainee injured or blood visible, enquire whether the interpreter has experience with this and can tolerate disturbing sights. The doctor should enquire whether the interpreter has ever suffered “vicarious trauma” and try to adjust the setting accordingly. The doctor should consider whether sitting or standing is preferred. Where the interpreter sits or stands depends on the situation and the language being used. For a spoken language interpreter, sitting comfortably between the two speakers is appropriate to aid the easy flow of communication. However, there may be some difference in sign language interpreting as sign language interpreters will usually sit or stand beside the speaker and opposite the deaf person. This enables the deaf person and the interpreter to see each other’s signs easily and allows the deaf person to have eye contact with both the speaker and the interpreter. Interpreters tend to follow directions of a doctor as much as doctors tend to follow guidelines of police officers in security matters and risk assessments when seeing detainees in custody. A sign language interpreter may

also request a change of lighting, such as drawing curtains or turning a light up to allow the deaf person and the interpreter to see each other clearly.

- c) When using an interpreter the doctor should aim at avoiding his own foreign language skills. The doctor may speak some words of the other language. It is permissible to use his skills to greet a person and establish rapport, such as expressing pleasure at seeing someone again. However, once the appointment begins it is best to leave bilingual skills to the accredited interpreter or translator that has been booked specifically for this purpose. This will avoid misunderstandings such as re- or back-interpreting a word or term into the first language when the doctor uses a term in the foreign language.
- d) It is very important for the doctor to understand that the interpreter is simply the communication aid and needs to be regarded as such. The doctor should avoid asking the interpreter, “How is he (the patient)?” but instead address the patient with, “How are you?” The interpreter will then convey the question into the second language. The doctor should primarily look at the patient and regard him or her as the communication partner. This requires the doctor’s trust that the term or question is expressed in the same way and manner by the accredited interpreter. The doctor should try to imagine that the interpreter is not present, despite the fact that the patient may make the mistake of addressing the interpreter rather than the doctor. The doctor may not be able to avoid this mistake by the subject, but can ensure he or she avoids it and looks at the actual communication partner, that is the patient. Mistakes by addressing the interpreter may in extreme cases lead to “interviewing or interrogating the interpreter” instead of the subject. This may require of the interpreter to interrupt the task and explain or re-explain their professional role which may lead to delays and add to confusion.
- e) An interpreter will continue to interpret at all times as the task is to convey what is said in the subject’s environment so that the subject understands everything that is spoken. If the doctor wishes to have a private conversation with another person in the room, he or she should step out and discuss the issue, leaving the interpreter with the client.
- f) It is important for the doctor to speak “naturally” and “normally”. The interpreter will indicate if the doctor is speaking too quickly or too much at one time and needs to pause. The doctor should be aware that spoken language interpreters may direct him when to stop and start speaking, allowing the interpreter time to interpret the message to the client. This will also render it clear to the doctor when a little pause is made by the interpreter but the section not fully conveyed at that moment. Sign language interpreters generally interpret simultaneously, which means they will sign at the same time that the doctor speaks. The doctor should avoid an over-use of jargon, slang or idiomatic expressions.
- g) Interpreting requires of a doctor to listen more attentively and possibly without interrupting. The doctor should also allow a little more time for the meeting, for example adding 15 min for every hour.
- h) The doctor should be careful not to assume that a subject’s nodding indicates either understanding or acceptance of what has been said. In some cultures it can merely indicate respect.
- i) At times an interpreter will ask for clarification of a term. At that point he will address the doctor directly. The doctor may be asked to repeat what has been said.
- j) The interpreter may at times take longer than the doctor expects, which may be required when cultural explanation is

required to give complete meaning to a situation. Interpreters are professionals and their goal is to ensure that all parties understand each other clearly. If one party is unsure of anything, asking is advised. The subject always has the right to ask if matters are unclear, and the doctor should clearly outline and emphasise this before the assessment.

- k) An interpreter can be a cultural aid who is able to give the doctor cultural feedback that increases understanding of reactions and responses. The doctor should know that he or she is entitled to cultural interpretation as a way of clearly understanding the interaction.
- l) The doctor should be aware that the task of an interpreter requires constant listening, speaking and concentration. It may be necessary to consider a break for the interpreter to allow him or her to render the most accurate and focused service. The doctor can budget the level of focus. However, this to do is more difficult for the interpreter as he or she is not in control of the assessment strategy and duration.

10. Finally the doctor should be aware of what the interpreter won't do

The interpreter should not and will not side with the non-English speaking client as the interpreter is an impartial professional who is there for the benefit of both parties. He or she will not interject or offer his own opinion. The interpreter will not enter into private discussion with either the doctor or the subject but will interpret every word that is spoken or signed. He or she should not act as a "witness" to any forms or declarations. This includes capacity statements and assurance statements whether a subject "has understood what was said".³⁷

11. Other problems related to interpreting

Forensic physicians may be involved in cases during which the police employ telephone interpreting services. This may render interpreting harder as the interpreter may not be able to see non-verbal clues or signals from the subject, doctor or police officer. The interpreter is entirely dependent on what is spoken. If the doctor makes the mistake to address the interpreter instead of the subject in his assessment, confusion can arise. The use of the third person instead of the second person singular may add to it. Other issues regarding telephone interpreting could include the fact that the interpreter may be based in a different country from where he provides the service. The interpreter may or may not be subject to the same legal or ethical obligations as he would be in the country in which the police and doctor operate and for whom he provides the service. For example, regarding confidentiality, there is little guarantee as to what the interpreter will do with the information he gained during the assessment when he is not bound by a respective legal and ethical framework in the country from which he does his job. There is the call for specific protocols on training and performance for telephone interpreters.^{38,39}

A similar problem can arise with courts using interpreting services related to video-conferencing. The configuration of a "distributed courtroom" instead of the traditional "co-present courtroom" could render the perception of the organisation and succession of speech episodes more blurred for the participants. Non-verbal clues may not be seen. Backchannel communication between interpreter and subject or doctor, that is low voice interpretation with the possibility of explanations without interrupting the speaker, may not be possible because of the shift in the interpreter's positioning.⁴⁰ The courtroom interpreting shows that a judge needs to have good understanding regarding how to use an

interpreter in the organisation of a trial. The same counts for the doctor's organisation of his assessment involving an interpreter.

12. Conclusion

The use of an interpreter has become more important in the course of increased global cultural and lingual mixing. Traditional medical and forensic medical training has not given emphasis to considerations regarding engagement with foreign language speakers, although legislation and guidelines have changed with this respect. Attempts to correct historic and cultural issues have contributed to the recognition of the need to re-think the organisation and implementation of foreign language facilitating services. The inclusion of such understanding in the basic and post-graduate medical training is proposed. To learn from successful dealings of the Australian Medical Council with the problematic of language diversity, communication and language compilation and integration is recommended. More research as to failings of the Criminal Justice System due to lack of providing appropriate interpreting services is required. Protocols and policies should be established as to the safe and appropriate use of interpreters in the forensic medical setting. The health and safety of the interpreter also with regard to disturbing sights and potential vicarious trauma is to be considered.

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